PRINTED: 07/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		445439	B. WING			07/24/2013	
NAME OF	PROVIDER OR SUPPLIER			Ś	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
MT 461 1	ET HEALTH CARE C	ENTED	i	2	650 NORTH MT JULIET ROAD		
m, 902)				N	NOUNT JULIET, TN 37122		
(X4) ID		TEMENT OF DEFICIENCIES	10	`	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION
		The second secon	IAG		DEFICIENCY)	RMIE	, =
Foon	MITTAL DOLLAR						
F 000	INITIAL COMMENT	18	FO	100			
	During a Basseliffe	otion Survey and Samulates					
	Investigation for TN	ation Survey, and Complaint					
	: TN_21756 TN_217	-31360, 114-31757, 30, TN-31695, and TN-31615,					
	conducted July 22 1			ı			i
	deficiencies were c	ited in relation to the					
	complaints under 4			ļ			
	Requirements for L	ong Term Care.		j	F 272 483.20 (b) (1) COMPREHENSIVE		
F 272	483.20(b)(1) COMF	PREHENSIVE	F2	72	ASSESSMENTS 5S=D		
SS=D	ASSESSMENTS		· -		33=9		
				İ	Requirement:	•	•
	The facility must co	nduct initially and periodically])
ļ		ccurate, standardized		ŀ	The facility must conduct initially and		
	reproducible assess	sment of each resident's		Į	periodically a comprehensive, accurate,		
	functional capacity.			İ	standardized reproducible assessment		
	A facility must make	a comprohensia			of each resident's functional capacity.	!	1
İ	assessment of a res	sident's needs, using the			A S-SUA		
	resident assessmer	nt instrument (RAI) specified			A facility must make a comprehensive assessment of a resident's needs, using		1
	by the State. The s	ssessment must include at		ł	the resident assessment instrument		
	least the following:				(RAI) specified by State. The assessment	i	1
	Identification and de	mographic information;			must include, at least, the following:	I	,
	Customary routine;			1	Identification and demographic		
	Cognitive patterns;				Information; customary routine;		
	Communication;				cognitive patterns; communication;	:	{
	Vision;	1	•	ĺ	vision; mood and behavior pattern;	i	
	Mood and behavior				psychosocial well-being; physical		
	Psychosocial well-b			- }	functioning and structural problems;	:	
1		and structural problems;		- 1	continence; disease diagnosis and	•	†
	Continence;				health conditions; dental and nutritional		
	Disease diagnosis a	ind health conditions;			status; skip conditions; activity pursuit;		
	Dental and nutritions Skin conditions;	aı status;			medications; special treatments and		1
	Activity pursuit:				procedures; discharge potential; documentation of summary information]
	Medications;			1	regarding the additional assessment		,
	Special treatments a	and procedures:		1	performed on the care areas triggered	ļ	
-	Discharge potential;	and broocenies!			by the completion of the Minimum Data	ŀ	
		ımmary information regarding		Ţ	Set (MDS); and documentation of	ì	
1		a		_	participation in assessment.		
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER SEPREBENTATIVES SIGN	ATURE		A JME - 14.		(Xe) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulsite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	445439	B. WING			07	07/24/2013	
PROVIDER OR SUPPLIER ET HEALTH CARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2660 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122			<u>. </u>		
REFIX REACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REACH CORRECTIVE ACTION SHOULD BE				D BE	(XB) COMPLETION DATE		
the additional asses areas triggered by t Data Set (MDS); an	sment performed on the care he completion of the Minimum d	F2	72	Corrective Action: The facility will conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.			
by: Based on medical r facility policy review, failed to assess one dialysis treatments f dialysis (The mecha waste products from effective kidney func The findings include Resident #137 was a with diagnoses include Disease, Complex P Hypothyroidism, Mal Diabetes. Medical record revie (MDS) dated June 2 resident required min person for bed mobil in the halfway. Contithe resident scored 1 interview for Mental si impairment.	ecord review, observation, and interview the facility resident (#137) receiving or one resident reviewed on nical process of removing the blood in the absence of the blood in the absence of the blood in the absence of the blood in the absence of the blood in the absence of the blood in the absence of the blood in the absence of the blood in the Brief Status indicating no cognitive			7/24/13. 2.There are currently no other residents residing in the facility that receive dialysis services. The nursing staff was in-serviced on 7/24/13 and 8/6/13 by the DON & ADON regarding the facility guidelines		8/6/13	
Review of the Nurse	s Admission/Readmission		_				
	PROVIDER OR SUPPLIER ET HEALTH CARE CE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa the additional assess areas triggered by to Data Set (MDS); an Documentation of p This REQUIREMENt by: Based on medical refacility policy review, failed to assess one dialysis treatments of dialysis (The mecha waste products from effective kidney function The findings include Resident #137 was a with diagnoses include Resident #137 was a with diagnoses include Resident #137 was a with diagnoses include Disease, Complex P Hypothyroidism, Mal Diabetes. Medical record revie (MDS) dated June 2 resident required min person for bed mobil in the halfway. Conti- the resident scored of interview for Mental simpairment.	PROVIDER OR SUPPLIER ET HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to assess one resident (#137) receiving dialysis treatments for one resident reviewed on dialysis (The mechanical process of removing waste products from the blood in the absence of effective kidney function). The findings included: Resident #137 was admitted on June 10, 2013, with diagnoses including End Stage Renal Disease, Complex Partial Seizures, Hypothyroidism, Malnutrition, Hypertension, and Diabetes. Medical record review of the Minimum Data Set (MDS) dated June 24, 2013, revealed the resident required minimal assistance with one person for bed mobility, transfers, and ambulation in the halfway. Continued MDS review revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status indicating no cognitive	A BURD A 445439 B. WING PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 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A SULDING 445439 REQUIDER OR SUPPLIER ET HEALTH CARE CENTER SUMMARY STATEMENT OF DEPOCEMORS (CACH DEPICIENCY MISS THE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. F 272 Corrective Action: The facility will conduct initially and periodically a comprehensive, accurate, standardized, reproducible sessment of each resident a functional capacity. 1. Resident #137 was discharged from the facility policy review, and interview the facility for dialysis treatments for one resident reviewed on dialysis treatments for one resident reviewed on dialysis treatments for one resident reviewed on dialysis treatments for one resident reviewed on dialysis in the facility that need dialysis services, the chirge nurses will perform required assessments and documentation. As patients are admitted to the facility that need dialysis services, the chirge nurses will perform required assessments and documentation. As patients are admitted to the facility that need dialysis services, the chirge nurses will perform required assessments and documentation assessments and documentation. As positional are admitted to the facility that need dialysis are included in the new hire orientation process. A Nurse management and the OA Committee will monitor the need and record for new hired nurses. Medical record review of the Minimum Data Set (MDS) dated June 24, 2013, revealed the resident required minimal assistance with one person for bed mobility, transfers, and ambulation in the hallway. Continued MDS review revealed the resident scored 14 out of 15 on the Brief interview for Mental Status indicating no cognitive mpairment.	A SULDING A SULDING A SULDING BY TREET ADDRESS, CITY, STATE, ZIP CODE SOMMARY STATEMENT OF DEPICIENCIES (ACH DEPICIENCY MUST BE PRECEDED BY SULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to assess one resident (#137) receiving dialysis treatments for one resident reviewed on dialysis (The mechanical process of removing waste products from the blood in the absence of effective kidney function). 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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F 272 Continued From page 2 Assessment dated June 10, 2013, revealed " Admission Note: .Res (resident) has port on upper R (right) chest. On dialysis. End Stage Renal Fallure" Review of the Daily Skilled Nurses Notes dated July 17 (Wednesday), July 19 (Friday), and July 22, 2013 (Monday), revealed the resident was out of the facility on all three days for dialysis. Continued review of the same nurse's notes revealed no documentation the resident was assessed upon return to the facility after receiving dialysis treatment. Review of the facility policy, Dialysis Patient Services, revealed, "There are several special interventions to be implemented with a patient receiving dialysis5Condition of patient before dialysis and upon return; Consumption of and adherence to diet" Interview with the resident on July 22, 2013, at 3:27 p.m., in the resident's room, confirmed the resident received outpatient dialysis breatments for end stage renal disease on Monday, Wednesday, and Friday of each week.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MATE OF PROVIDER OR SUPPLIER MT JULIET HEALTH CARE CENTER SUMMARY STATEMENT OF DEPICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) F 272 Continued From page 2 Assessment dated June 10, 2013, revealed " Admission Note: . Res (resident) has port on upper R (right) chest. On dialysis. End Stage Renel Failure" Review of the Daily Skilled Nurses Notes dated July 17 (Wednesday), July 19 (Friday), and July 22, 2013 (Monday), revealed the resident was assessed upon return to the facility after receiving dialysis treatment. Review of the facility policy, Dialysis Patient Services, revealed, "There are several special interventions to be implemented with a patient receiving dialysis and upon return; Consumption of and adherence to diet" Interview with the resident on July 22, 2013, at 3.27 p.m., in the resident on July 22, 2013, at 3.27 p.m., in the resident flaysis treatments for end stage renal disease on Monday, Wednesday, and Friday of each week.			445439	B. WING			07	/24/2013
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Interview on July 24, 2013, at 1:33 p.m., at the nurse's station, with Licensed Practical Nurse (LPN) #3 who was present on the days the resident returned from dialysis confirmed the resident had not been assessed after receiving dialysis. Continued interview with LPN #3 confirmed LPN #3 had no knowledge of the assessment documentation required for residents receiving dialysis. Interview with the Assistant Director of Nursing on July 24, 2013, at 1:45 p.m., at the nurse's station,		Assessment dated and Admission Note:Review of the Daily July 17 (Wednesday 22, 2013 (Monday), of the facility on all the Continued review of revealed no docume assessed upon returned interventions to be interview with the resident received out for end stage renal of Wednesday, and Frinterview on July 24, nurse's station, with Interview on July 24, nurse's station on July 24, nurse's station on July 24, nurse's station on July 2	June 10, 2013, revealed " es (resident) has port on it. On dialysis. End Stage Skilled Nurses Notes dated if), July 19 (Friday), and July revealed the resident was out hree days for dialysis. The same nurse's notes entation the resident was in to the facility after receiving in policy, Dialysis Patient "There are several special implemented with a patient incondition of patient before turn; Consumption of and sident on July 22, 2013, at dent's room, confirmed the tipatient dialysis treatments lisease on Monday, day of each week. 2013, at 1:33 p.m., at the Licensed Practical Nurse resent on the days the in dialysis confirmed the in assessed after receiving interview with LPN #3 and no knowledge of the intation required for residents	F 2	:72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
445439		445439	B. WING		67	07/24/2013	
ľ	NAME OF PROVIDER OR SUPPLIER MT JULIET HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, 28 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122	PCODE	12-42010	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL G IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
ŞŞ≏D	confirmed the facility assessment of residences and the facility must use the develop, review a comprehensive plan. The facility must develop for each residence objectives and timets medical, nursing, and needs that are identificated assessment. The care plan must do be furnished to attain highest practicable posychosocial well-be \$483.25; and any selbe required under \$483.10, including the under \$483.10, including the under \$483.10 (b)(4). This REQUIREMENT by: Based on medical residences assessment.	y policy was not followed for lents receiving dialysis. (1) DEVELOP CARE PLANS The results of the assessment and revise the resident's of care. Telop a comprehensive care at that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive Telop a comprehensive care at that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive	F 2	F 279 483-20(k)(1) DEVELOPA COMPREHENSIVE CARE PLANS SS=D Requirement: A facility must use the results of assessment to develop, review revise the resident's comprehe plan of care. The facility must develop a comprehensive plan of care for resident that includes measure objectives and time tables to make the resident's medical, nursing and and psychosocial needs that an identified in the comprehensive assessment. The care plan must describe the that are to be furnished to attain maintain the resident's highest practical, physical, mental, and psychosocial well-being as required under 483-25; and any services would otherwise be required under 483-25 but are not provided duresident's exercise of rights under 483-10, including the right to re	of the and and ansive ansive ansive and ansive and ansive ansive and another ansive and ansive and ansive and ansive and ansive and another ansive and another ansive and another ansive and another another and another an		
	resident, # 91, of fort	cation interventions for one y-one residents reviewed.		treatment under 483,10(b)(4).			
.	The findings included Resident # 91 was ac 14, 2013 with diagnos	Imitted to the facility on June	, <u></u>	The facility will use the results of assessment to develop, review a revise the resident's comprehent plan of care.	end		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445439	B, WING		07/24/2013	
ļ	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122			7 <u>24/2010</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(XS) COMPLETION DATE
	Fibrillation, Hyperte Pacemaker, Type 2 Medical Record Ret Administration Record 2013, revealed the in Coumadin (an antio Continued review rewas adjusted on July 9, 2013. Medical record review or precautions related present. Interview with the Asson July 24, 2013, at station, confirmed the Nursing interventions therapy for the resident has the incompetent or other incapacitated under the participate in planning changes in care and A comprehensive call within 7 days after the comprehensive asset interdisciplinary team physician, a registere for the resident, and disciplines as determined and the comprehensive asset interdisciplines as determined and disciplines as determined and the comprehensive asset interdisciplines as determined and disciplines as determined and the comprehensive asset interdisciplines as determined and disciplines as determined and the comprehensive asset interdisciplines as determined and the comprehensive and th	nsion, Status Post Cardiac Diabetes, and Hypoxemia. View of the Medication ords (MAR) for June and July, resident was prescribed cagulant medication). Evealed the Coumadin dosage ne 21. June 27, July 5, and ew of the Plan of Care dated aled no nursing interventions, and to anticoagulant therapy efacility failed to care-plan as specific to anticoagulant ent. (k)(2) RIGHT TO INING CARE-REVISE CP oright, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment.	F 28	updated on 7/24/13 to reflect nursing interventions and precautions related to anticoagulant therapy. 2. The care plans for each resident or anticoagulant therapy has been reviewed and updated, when indicated on 7/25/13. The MDS Coordinator was in-serviced on 7/25/13 by the DON regarding facility guidelines for developing, reviewing and revising resident's care plan. 3. The MDS coordinators will develop, review and revise resident's care plans according to facility guidelines to ensure nursing interventions and precautions are current and appropriate. 4. Nurse management and the QA Committee will monitor the care plans for patients on anticoagulant therapy monthly to ensure compliance and		7/25/13

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		I AND HUMAN SERVICES 8 MEDICAID SERVICES			FORM	APPROVE	
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	PLE CONSTRUCTION	(X3) DA7	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		445439	B. WING		0.7	/24/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MT JULI	ET HEALTH CARE CE	NTER		2660 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	DBE	(X5) COMPLETION DATE	
	the resident, the resideal representative and revised by a tea each assessment. This REQUIREMENT by: Based on medical rand interview the fact Plan for two resident residents reviewed. The findings include Resident #79 was a August 3, 2009, with Dementia, Behaviors Post Right Hip Fract Degenerative Joint Community of the care plan had no interventions for fall thad fallen.	aident's family or the resident's and periodically reviewed am of qualified persons after of qualified persons after of qualified persons after ecord review, observation, cility failed to revise the Care ts (#79 and #92) of forty one diagnoses including al Signs/Symptoms, Status ure, Osteoporosis, Disease, and Anxiety. W of a Nurse's Event Note evealed in sounding and went into dent on the floor of bathroom rResident picked up and the current Care Plan ity on July 6, 2013, revealed to been revised with new precautions after the resident or of Nursing on July 24.	F 280				
	had fallen. Interview with Directo						

the Care Plan had not been updated or revised to

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			(M APPROVEL D. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445439	B. WING	3	·	67	//24/2013
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	_ Ui	<u> [24/20 5 </u>
MT JULI	IET HEALTH CARE CE	INTER			650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
	Resident (#92) was April 14, 2010, with Ischemic Attack, Rigsided Weakness, Hibementia. Medical record revie Administration Record revealed, " clean risaline), pat dry, appilional change q (evelout with w/c (wound clear resolved DTI (deeploint (ointment) apply fower extremities) Bineeded), clean risolower extremities bineeded (Sunda). Medical record reviewed revealed the resident with an onset date of Medical record reviewed.	admitted to the facility on a diagnoses including Transient ight Cerebral Infarct with Left diagnoses including Transient ight Cerebral Infarct with Left diagnoses including Transient ight Cerebral Infarct with Left diagnoses, and ew of the Medical ord (MAR), for July 2013, (right) heel with NS (normal oly collagen, cover with border ary) day, "clean r malleolus canser) apply skin prep until tissue injury)Dermaphor y topically to BLE (bilateral old) (two times a day) pro (as not toes with w/c apply otic ointment), leave OTA (on I resolved, wkly (weekly) skin of the Weekly Wound do June 14 to July 24, 2013, and had a deep tissue injury of June 20, 2013.		280			8/15/13
]	resident had a deep	t 28, 2012, revealed the tissue injury on the right May 24, 2013, and no e right heel.					
	Interview with Licens on July 24, 2013, at	sed Practical Nurse (LPN #5) 10:00 a.m., at the nursing					

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_		& MEDICAID SERVICES			OMB NO	0.0938-039	
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA	(XS) DATE SURVEY COMPLETED	
	·	445439	B. WING,	, , , , , , , , , , , , , , , , , , ,	07	07/24/2013	
	PROVIDER OR SUPPLIER ET HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP (2650 NORTH-MT JULIET ROAD MOUNT JULIET, TN 37122	CODE	ZEWEVIO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	Y SHOULD BE	(X5) COMPLETION DATE	
	station, confirmed to pressure ulcer on the pressure ulcer to the of June 14, 2013, as revised to accuratel pressure ulcers. 483.25(c) TREATMI	ne resident did not have any te right malleolus, had a pright freel with an onset date and the care plan had not been by reflect the resident's	F 21		°S TO		
SS=D	resident, the facility who enters the facility who enters the facilit does not develop prindividual's clinical of they were unavoidated pressure sores recesservices to promote prevent new sores fi	rehensive assessment of a must ensure that a resident by without pressure sores essure sores unless the ondition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and rom developing.		PREVENT/HEAL PRESSURE SORES SS=D REQUIREMENT: Based on the comprehensive assessment of a resident, the facili must ensure that a resident who e the facility without pressure sores not develop pressure sores unless individual's clinical condition demonstrates that they were unavoidable; and a resident having	ity inters does the		
	by: Based on medical re and interview, the fac	T is not met as evidenced ecord review, observation, cility failed to timely and e pressure ulcers of resident sidents reviewed.		pressure somes receives necessary treatment and services to promote healing, prevent infection and previous somes from developing.	2		
	14, 2010, with diagnor Ischemic Attack, Rigi Sided Weakness, Hy Dementia.	initted to the facility on Apriloses including Transient of Cerebral Infarct with Left pertension, Diabetes, and	•		•		

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	RS FOR MEDICARE	OMB N	OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION MG	(EX)	ATE SURVEY OMPLETED			
		445439	B. WING			7/24/2013			
NAME OF	PROVIDER OR SUPPLIER	<u>, , , , , , , , , , , , , , , , , , , </u>		STREET ADDRESS, CITY, STATE, ZIF		(/442013			
MT JULI	ET HEALTH CARE CE	ENTER	ľ	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI- DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	Data Set dated May resident had severe unstageable deep to Medical record revide August 28, 2012 and 5, 2013, revealed the right heel ulcer which 1, 2012, and again a Further review revealed on May 24 deep tissue injury to Further review revealed on May 24 deep tissue injury to Further review revealed on May 24 deep tissue injury to Further review revealed on May 24 deep tissue injury to Further review revealed on May 24 deep tissue injury to Further review revealed on May 24 deep tissue injury to Further review revealed on July 1, and July 1, and July 1, and July 1, and July 1, 2013 for the right heel with an 2013. Medical record review progress note dated right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the right heel was documented to make the review of the right heel was documented to make t	28, 2013, revealed the ely impaired cognition and one issue injury. ew of the Care Plan dated devised March 8 and June are resident had a reoccurring the was resolved on October resolved on March 21, 2013, aled the resident had a deep of theel on March 21, 2013, 1, 2013. Further review, 2013, the resident had a the right malleolus (ankle), aled "refer to weekly wound and) physician orders for" ew of the Non-Ulcer Weekly wound and wound assessments alleolus. ew of the Weekly Wound alled assessments were 14, June 20, June 21, July 2, an unstageable wound on a onset date of June 20, w of the weekly wound June 20, 2013, revealed the nented as a stage Illimeters (cm) by 1.8 (cm) with	F 3*	The facility will ensure that a resi who enters the facility without processores does not develop pressure unless the individual's clinical condemonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promothealing, prevent infection and processores from developing. 1. The pressure ulcer of resident it was accurately re-assessed on 7/3 and the documentation and care was updated accordingly. 2. The treatment nurse was in-sent on 7/28/13 and 8/8/13 by the DO the facility guidelines for measuring staging and documenting pressure ulcers. All pressure ulcers has bee assessed on 7/28/13 by a visiting treatment nurse and the documential be reviewed/revised for accurately and timeliness by 8/2 a. The treatment nurse will complete weekly pressure ulcer assessment required documentation according facility guidelines. 4. Nurse management and the QA Committee will monitor 100% of pressure ulcer documentation were 4, then 50% monthly for compliant the corrective action plan will be modified as Indicated, to establish substantial compliance.	ressure sore: ndition PE Y te event 192 24/13 plan viced: nto nte nte s and g to ekly X ce.	8/15/13			
	Medical record revie Progress Note dated	w of the Weekly Wound June 21, 2013, revealed the							

PRINTED: 07/30/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 445439 B. WING. 07/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MT JULIET HEALTH CARE CENTER MOUNT JULIET, TN 37122 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY Continued From page 9 F 314 right heel was documented as a deep tissue injury appearing as a stage II measuring 2.4 (cm) by 1.8 (cm) with a depth of less 0.2 (cm). Medical record review of the residents Care Plan.

physician's orders, wound progress notes. treatment record, and nursing notes for May and June, 2013, revealed the wound to the right maileolus was discovered May 21, 2013, treatment orders were obtained and implemented appropriately, and the wound was still present on the right malleolus. Further review revealed treatment for the wound on the right heel began on June 14, 2013.

Observation of the resident's right foot on July 24, 2013, at 8:40 a.m., with Licensed Practical Nurse (LPN #5) in the residents room, revealed the resident had a pressure ulcer described as "unstageable" on the right heel measuring 5.5 (cm) by 4.5 (cm) with unable to determine depth due to eschar (black, hard coating). Further observation revealed no visible wound to the right malleolus.

Interview with LPN #5 on July 24, 2013, at 10:00 a.m. at the nursing desk, and review of the medical record with the LPN, confirmed the resident had a reoccurring unstageable pressure ulcer to the right heel with physicians orders and appropriate treatment for an unstageable pressure ulcer implemented on June 14, 2013. Continued interview and medical record review confirmed the resident did not have a pressure ulder to the right malleolus, there were no orders or notes indicating when the right malleolus uicer had resolved and weekly assessments had not been performed. Continued interview and medical record review confirmed the wound

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445439	B, WING_		07/	07/24/2013	
	PROVIDER OR SUPPLIER ET HEALTH CARE CE	NTER		STREET AODRESS, CITY, STATE, ZIP CODE 2550 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122			
(XA) ID PREFIX TAG				LD BE	(XS) COMPLETION DATE		
	developed on June orders indicated the June 14, 2013. Cor record review confir assessments for Ju accurate and consist assessments had n Continued interview assessments of word accurately and considerately incomplete the facility with a limited range appropriate treatme	cated the right heel wound 20, 2013, but physician's wound had an onset date of nitinued interview and medical med the wound progress note ne 20 and 21, 2013 were not stent, and weekly ot been completed. confirmed weekly unds had not been completed elstently. EASE/PREVENT DECREASE FION rehensive assessment of a must ensure that a resident of motion receives nt and services to increase Vor to prevent further	F 3′	F318 483.25(e){2} INCREASE/PREVENT DECREASE IN RANGE OF MOTION			
	by: Based on medical rand interview, the faresident (#31) had a The findings include Resident #31 was a 10, 2013, with diagn Disorder, Hypertens with Senile Psychos Failure.	ecord review, observation, cility failed to ensure one wrist splint in place. d: dmitted to the facility on April oses including Seizure ion, Depression, Dementia is, and Congestive Heart physician's order dated May		Corrective action: The facility will ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. Resident #31 was assessed by the orthopedic on 7/9/13 for the use/need of the wrist splint, and a new order was received to D/C the wrist splint as recorded in the nurses notes. The MD order to D/C the splint was written or 7/29/13 and the care plan was updated to reflect the change.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
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WIT HILL	IET HEALTH CARE CE	*1 mm		2650 NORTH MT JULIET ROAD			
		<u> </u>	MOUNT JULIET, TN 37122				
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F 323 SS=D	splint on the left wrist the July 2013, recap resident was to wear consider the July 2013, recap resident was to wear consider the hallway with no Observation on July revealed the resident hallway, with no splin Observation on July revealed the resident area and was not we wrist. Observation and interest the provided the resident area and was not we wrist. Observation and interest the provided the resident wearing the left wrist the left wrist the facility must ensenvironment remains as is possible; and expressible; and expression was to write the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was to write the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was the servironment remains as is possible; and expression was	the resident was to have a st. Medical record review of pitulation orders revealed the ar a splint on the left wrist. y 23, 2013, at 4:15 p.m., on the was in the wheelchair sitting no splint on the left wrist. y 24, 2013, at 8:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 25, 26, 27, 28, at 10:40 a.m., on the left wrist. y 26, 2013, at 10:40 a.m., on the left wrist. y 27, 2013, at 10:40 a.m., on the left wrist. y 28, 2013, at 10:40 a.m., on the left wrist. y 29, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 22, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 24, 2013, at 10:40 a.m., on the left wrist. y 25, 2013, at 10:40 a.m., on the left wrist. y 26, 2013, at 10:40 a.m., on the left wrist. y 26, 2013, at 10:40 a.m., on the left wrist. y 27, 2013, at 10:40 a.m., on the left wrist. y 28, 2013, at 10:40 a.m., on the left wrist. y 29, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wrist. y 21, 2013, at 10:40 a.m., on the left wris	F 32	2. The nursing staff was in-serviced on 7/26/19 and 8/8/13 by the DON regarding adhering to and processing physician's orders when received according to facility guidelines. The imedical record for other residents with splints ordered was audited on 7/28/13 to ensure residents with splints have appropriate physician's orders in place. 3. The nursing and restorative staff will make sure that splints are applied as indicated by the resident's care plan and in accordance with the facility guidelines. The restorative team was inserviced on 8/s/13 by the DON regarding their responsibility in the process for managing residents splints. The nursing staff will process physician's orders when received according to facility guidelines. 4. Nurse management and the QA Committee will monitor the medical record for those resident's with splints weekly X 4, then 10% monthly X6 and ensure compliance with facility guidelines. The corrective action plan will be modified as indicated, to establish substantial compliance. 23 F323 483.25(h) FREE OF ACCIDENTS/HAZARDS/SUPERVISIONS/ DEVICES SSOD The facility must ensure that the resident's environment remains as free		8/15/13	
	This REQUIREMEN	T is not met as evidenced		of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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11111		445439	8. WING			07	/24/2013
	PROVIDER OR SUPPLIER ET HEALTH CARE CE	NTER		26	TREET ADDRESS, CITY, STATE, ZIP CODE 850 NORTH MT JULIET ROAD IOUNT JULIET, TN 37122		
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	by: Based on medical review of facility invitacility failed to imple for one resident (#7 reviewed, and failed chemicals in the beat the findings included Resident #79 was a August 3, 2009, with Dementia, Behavior Post Right Hip Fract Degenerative Joint I Medical record reviewed assistance the last assess transfers and tolleting since the last assess Medical record reviewed July 6, 2013, relarm sounding and resident on the floor wheelchair Resider commode* Further did not have any injuice the care plan was uphad a fall on July 6, 2 interventions had beinterventions had beinterventions had beinterventions and paid a fall on July 6, 2 interventions had beinterventions had beinterventions had beinterventions fall on July 6, 2 interventions had beinterventions had beinterve	record review, observation, estigation, and interview, the ement interventions after a fall 9) out of forty one residents I to secure hazardous auty shop. ed: dmitted to the facility on a diagnoses including al Signs/Symptoms, Status ture, Osteoporosis, Disease, and Anxiety. It wo of the Quarterly Minimum 20, 2013, revealed the by impaired cognition; required to of two plus persons for 19; and had not had any falls sment. It wo fa Nurse's Event Note evealed " Nurse heard went into room and found of bathroom in front of the picked up and put on the review revealed the resident ries. It wo fine current Care Plan ity on July 6, 2013, revealed idated to indicate the resident 2013, but no new en added to the care plan.	F	323	Corrective Action: The facility will ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The fall for resident # 79 was thoroughly investigated and a new intervention and precaution was implemented on 7/31/19, and the care plan was updated accordingly. The facility secured and/or removed hazardous chemicals and supplies behind fock and key in cabinets stored in the beauty shop on 7/22/13. 2. An audit of care plans for falls was conducted on 7/30/13 by nurse management, for appropriate nursing interventions and precautions. The care plans will be updated with appropriate interventions and precautions by 8/15/19. The nursing staff was in-serviced on 8/7/13 by the DON regarding thoroughly investigating resident falls, how to identify the root cause and implementing an appropriate intervention timely. The beauty shop was inspected by the Administrator randomly between 7/22/13 and 8/1/13 to ensure cabinets were properly locked and all chemicals were properly stored.		
[;	July 6, 2013, reveale	/s investigation for the fall on dinterventions put in place				İ	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ___ 445439 B. WING 07/24/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MT JULIET HEALTH CARE CENTER MOUNT JULIET, TN 37122 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 323 Continued From page 13 F 323 3. The MDS Coordinator will review the were to place the resident in the hallway after the care plans weekly for those residents fall and to supervise the resident while toileting. with falls and ensure they reflect appropriate interventions and Interview with the Director of Nursing on July 24, precautions to reduce fall risk. 2013, at 8:10 a.m., at the nurse's station. The maintenance director changed the confirmed the facility falled to do a thorough door handle on the beauty shop on investigation for the fall and falled to implement 8/1/13 to an automatic locking handle new interventions for fall precautions. requiring entry by key onty. 4. Nurse management and QA&A Observation on Monday, July 22, 2013, at 10:00 Committee will monitor care plans for a.m., in the beauty shop located on the 400 wing. residents who has had falls weekly X 4 revealed an unlocked door. Posted days of use then 50% monthly to ensure for the beauty shop were Tuesday, Wednesday, compliance. and Thursday. Observation inside the unlocked The Administrator, nurse management beauty shop revealed a container of Barbicide and QA Committee will conduct random liquid and combs without the lid. Continued facility rounds weekly X 12 to ensure all observation revealed a variety of unsecured chemicals and supplies are stored chemical hair products. The back of the room properly in the beauty shop. The corrective action plan will be revealed an area for central supplies which modified as indicated to obtain and consisted of two cabinets, one of which was maintain substantial compliance. unfocked. Inside the unlocked cabinet was one 8/15/13 bottle of hydrogen peroxide. Xeroform bandages and sterile dressing supplies. Interview on July 22, 2013, at 10:10 a.m., in the Beauty Shop with the acting Administrator. confirmed the door was unlocked and hazardous F441 483.65 INFECTION CONTROL chemicals and supplies were not secured. PREVENT SPREAD, LINENS F 441 483.65 INFECTION CONTROL, PREVENT F 441 SSeD. SPREAD, LINENS SS=D Requirement: The facility must establish and maintain an Infection Control Program designed to provide a The facility must establish and mair tain safe, sanitary and comfortable environment and an infection control program designed to help prevent the development and transmission. to provide a safe, sanitary and of disease and infection. comfortable environment and to help prevent the development and

transmission of disease and infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	<u></u>	445439	B. WING	;		07/	24/2013
	PROVIDER OR SUPPLIER IET HEALTH CARE CE			\$1 26	TREET ADDRESS, CITY, STATE, ZIP CODE 650 NORTH MT JULIET ROAD IOUNT JULIET, TN 37122	<u> </u>	2412010
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	(a) Infection Control The facility must est Program under whic (1) Investigates, cor in the facility; (2) Decides what pro- should be applied to (3) Maintains a reco- actions related to infection (b) Preventing Spread (1) When the Infection determines that a re- prevent the spread of isolate the resident. (2) The facility must communicable disea- from direct contact will tra (3) The facility must hands after each din hand washing is indi- professional practice (c) Linens Personnel must hand transport linens so a infection. This REQUIREMENT by: Based on observation Interview the facility for	of Program stablish an Infection Control stablish an Infection Control stablish an Infection Control stablish an Infection Controls, and prevents infections recedures, such as isolation, or an individual resident; and corrective affections. The analog of incidents and corrective affections. The analog of infection to control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. The analog of infection contact for which it is require staff to wash their rect resident contact for which it is at the prevent the spread of as to prevent the spread of an policy review, and failed to maintain infection follow practices to prevent on.	F 4	141	Carrective Action: The facility will establish and maintain an infection control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. The staff present during survey was in-serviced on 7/22/13 and 7/23/13 by the DON regarding hand hygiene and good hand washing according to facility guidelines. 2. All other staff will be in-serviced by 8/15/13 by the DON regarding hand hygiene and good hand washing according to facility guidelines. 3. The staff will follow facility guidelines for universal precautions, good hand washing and hand hygiene techniques to help prevent the spread of disease and infection. The facility guidelines will be reviewed in new hire orientation with return demonstration. 4. Nurse management and QA Committee will randomly observe staff weekly during medication administration and performing treatments to ensure universal precautions; good hand hygiene and hand washing is maintained according to facility guidelines. The corrective action plan will be modified if recommended by the QA Committee.		8/15/13
	The tindings indiqued	7:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED	
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F 441	Continued From pa	ge 15	F4	41			
	General, Hand Hygimust be performed donning gloves and Observation on July the three hundred he Practical Nurse #1 (medications to a rest Continued observation cart, drawer, retrieved cledisinfecting the hand Interview with LPN # a.m., in the hallway, disinfected the hand Resident (#92) was April 14, 2010, with elschemic Attack, Sm. Left Sided Weaknes and Dementia. Observation on July resident's room, revenues (LPN) #5 was supplies from cart, on the cart to put iter the lid to close it, and clean supplies. LPN again and opened the dressing with scisson	sident wearing gloves. on revealed the nurse exited removed gloves, returned to opened the medication ean medication, without					
	uie ka to close k.					_	

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		"IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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F 441	Continued From pa	ge 16	F 44	41		
		#5 on July 24, 2013, at 9:15		' '		
	a.m., outside the re	sident's room, confirmed the				
	trash can lid was co	ensidered dirty and hand		İ		
	hygiene should have	e been performed.				
F 514			F 51		ļ.	
SS≃D	RECORDS-COMPL LE	ETE/ACCURATE/ACCESSIB		COMPLETE/ACCURATE/ACCESSIBLE	:	
	LE	i		5S-D	:	
	resident in accordar	aintain clinical records on each		REQUIREMENT:		
	standards and pract	tices that are complete;		The facility must maintain clinical		1
	accurately documer	ited; readily accessible; and		records on each resident in accordance		
	systematically organ	nized.		with accepted professional standards	1	
-	The clinical record r	nust contain sufficient		and practices that are complete;		
	information to identif	fy the resident; a record of the		accurately documented; readily		1
	resident's assessme	ents; the plan of care and		accessible; and systematically		•
	services provided; ti	ne results of any		organized.	ı	ļ
	preadmission scree	ning conducted by the State;		The clinical record must contain		
]	and progress notes.			sufficient information to identify the		
				resident; a record of the resident's		
	This REQUIREMEN	T is not met as evidenced		assessments; the plan of care and		
Ī	by;	is not met as evidenced		services provided; the results of any		
-	Based on medical n	ecord review, facility policy		preadmission screening conducted by the state; and progress notes.		1
	review, and interview	v. the facility failed to ensure		:		
	the medical record v	vas complete for pain		Corrective Action:		
	assessments for one	e (#42) resident and a				}
	Priyercian s order Wa RiPAP (received on the	s obtained for the use of a reathing equipment) for one		The facility will maintain clinical records]
	resident (#103) of fo	rty-one resident's reviewed.		on each resident in accordance with		
1	·	TO THE TOTAL PROPERTY.		accepted professional standards and		
1	The findings include	d:		practices that are complete; accurately !		
	_			documented; readily accessible; and systematically organized.		
	Resident #42 was ac	Imitted to the facility on July		"laceting popul to Patitizary		
1,	17, 2008, with diagn∈ Diagna add Ciri	oses including Chronic Liver				
J	uisease and Ulffigs Denteedyn Disastor	is, Senile Delusion, Senile , Osteoarthrosis, Anxiety,				; ·
]	nahi assisa nisolget	, Oslevarurosis, Anxiety,		İ		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DATE SURVE COMPLETED	
		445439	B. WING		07/24/201	3
	PROVIDER OR SUPPLIER ET HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) (D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLE	EYTON
	Status Post Left Knothernia, Rheumatoid Pelvis. Medical record revis Administration Record Assessment Flow Sonot document the repain Assessment Flow Sonot document the repain Assessment Flow Sonot document the repain Assessment Flow Sonot document the repain Assessment Flow Sonot document the repain Assessment Flow Sonothernia Continues a day. Review of the facility revealed "The Painto be utilized for any symptoms of pain" Interview with the resonance painto and painto	ee Replacement, Hiatal Arthritis, and Fractured Arthritis, and Fractured Arthritis, and Fractured Arthritis, and Fractured Arthritis, and Fractured Arthritis, and Fractured Arthritis, and Pain heet revealed the facility did esident's pain levels on the ow Chart for the months of 2013. The resident received (pain medication) 10/325 four Assessment Flow Chart is complaints or signs and sident on July 24, 2013, at idents room revealed, "still in is regulated every four helps." Tector of Nursing (DON) on 5 p.m., in the DON office no documentation of pain is essesment Flow Chart for the 3, and July 2013. Edmitted to the facility on diagnoses including: Chronic ary Disease (COPD), all Fibrillation (irregular heart us type 2, Chronic Kidney esity, Renal Cancer, Anemia e resident was discharged	F 51	1. The charge nurse assessed resident's pain to determine pain level and effectiveness of pain medication and document results according to facility guidelines. Resident # 103 was discharged home on4/26/13. 2. Every resident on scheduled pain management will be assessed to determine pain levels and effectiveness of the scheduled medication regimen and document according to facility guidelines. An audit of the medical records for residents with 81PAP/CPAP in use was conducted on 7/28/13 to ensure physician's orders were properly in place according to facility guidelines. 3. The charge nurses was in-serviced on 8/8/13 by the DON regarding facility guidelines for pain management and required documentation. The charge nurses will assess and document each resident's pain levels and the effectiveness of the pain medication regimen according to facility guidelines. The nurses were in-serviced on 8/7/13 by the DON regarding facility guidelines for obtaining physician's orders for all care and services and processing accordingly. 4. Nurse management and the QA Committee will monitor medical records and perform random resident interviews weekly X4 then monthly to determine compliance. The correction action plan will be modified as indicated to establish compliance.	8/15/:	13

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION MG	(X3) DATE SURVEY COMPLETED	
		446439	B. WING_			
	PROVIDER OR SUPPLIER ET HEALTH CARE C			STREET ADDRESS, CITY, STATE, ZIP OF 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122	CODE	<u>/24/2013</u>
(X4) ID PREFIX TAG	i (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(XS) COMPLETION DATE
	resident scored a 1 Mental Status, indicognitively intact ar assistance with act Medical record reviadmission orders, can order for "O2 (needed; contact Mt direction" Continuorders revealed no machine (machine Medical record reviadpril 25, 2013, reve keeping O2 in use a Interview with Regis 24, 2013, at 12:30 p (DON) office, reveal the day of the dischictontinued interview the BiPAP at home a used while at the factoriations with the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication of the dischictory with the Diffication of the dischictory with the Diffication of the dischictory with the Diffication of the dischictory with the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication, in the Diffication of the dischictory with the Diffication of the dischictory with the Diffication, in the Diffication, in the Diffication of the dischictory with the Diffication of the disc	is on the Brief Interview for cating the resident was and did not require any ivities of daily living. iew of the physician's dated March 3, 2013 revealed (oxygen) 2-4 L (liters), as D (medical doctor) for further used review of the physician's written order for the BiPAP used to assist with breathing). Iew of a nurse's note, dated aled "reeducated on and wearing BiPAP at night" Istered Nurse (RN) #3, on July o.m., in the Director of Nursing led the RN was on the floor arge of the resident. I revealed the resident wore and the BiPAP was being cility. ON, on July 23, 2013, at ON office, confirmed the in a physician's order for the	F 51	4		